NC Medicaid Provider Enrollment
CSC EVC Center

P. O. Box 300020
Raleigh, NC 27622-8020

For certified /overnight mail only:
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073

Dear Organization Provider,

Thank you for your interest in enrolling as a North Carolina Medicaid Provider. In order for us to complete the process, please mail the following documents to CSC:

Complete and sign the following required documents:

- ☐ In State/Border Organization Provider Enrollment Application. The Authorized Individual listed on page 13 of the application must sign and date this application.
- ☐ NC Department Of Health And Human Services (DHHS) Provider Administrative Participation Agreement
- ☐ False Claims Letter of Attestation
- ☐ NC Division Of Medical Assistance (DMA) Provider Certification For Signature On File
- ☐ NC DHHS DMA Electronic Claims Submission (ECS) Agreement
- ☐ Substitute W-9 Request for Taxpayer Identification Number and Certification

You must also provide a current copy of the following:

- ☐ National Plan and Provider Enumeration System (NPPES) letter
- ☐ Licenses, certifications, accreditations, endorsements, etc.
- ☐ Border Providers: Your home state's Medicaid welcome letter
- ☐ If you selected Sole Proprietor or Single-Owner LLC: A copy of the applicant's EIN letter from the IRS

CABHA applicants must also provide:

- ☐ NPPES letter for Targeted Case Management for Mental Health and Substance Abuse (TCM/MH-SA) services, if the NPI# is different than the CABHA NPI#

Retain a copy of your completed In State/Border Organization Provider Enrollment Application packet and all documentation submitted for your records. You will be notified by mail once the enrollment process has been completed.

Billing information and clinical coverage polices (DMA): http://www.ncdhhs.gov/dma/provider/

Thank you again for your interest. If you have any questions or need additional information, please feel free to contact NC Medicaid Provider Enrollment at the CSC EVC Center at 866-844-1113 or email the CSC EVC Center at NCMedicaid@csc.com.

North Carolina Department of Health and Human Services
In State Organization Provider Enrollment Application

For assistance completing this application, please call the CSC EVC Center at 866-844-1113.

Organization Information

Organization Name – as shown on income tax return *

NPI *	Employer Identification Number (EIN) *
	-
Month of Fiscal Year End *	Do you operate under a trade or company name, (i.e., Acme Health Care Inc doing business as (DBA) Community Family Practice? *
	Yes No

Doing Business As (DBA) information

DBA Name

NC Secretary of State ID #	Years Doing Business Under This Name

Former Doing Business As (DBA) information

Have you used a different DBA Name?	Former NC Secretary of State ID#
Yes No	

Former Doing Business As (DBA) Name

Effective Date and Provider Number

Effective Date Requested (MM/DD/CCYY)	Note: The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment shall not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received by the CSC EVC Center and shall not precede applicable licensure/accreditation/certification/endorsement documents that are required for enrollment.
/ /	
Have you previously been enrolled as a provider with the Division of Medical Assistance? *	If yes, what is your NC DHHS Provider Number?
Yes No	

Change of Ownership/Merger/Acquisition

Is this application in conjunction with a change of ownership, stock purchase, change in a shareholder's/partner's percentage of interest in ownership, transfer of title, or a merger? *	Date of ownership change:	NC DHHS Number Assigned to Previous Owners(s)
Yes No	/ /	

Provider Type (Please select only one)

Ancillary

- ☐ Ambulance
- ☐ Hearing Aid Dealer [1]
- ☐ Optical Supplier

Case Management

- ☐ At Risk Case Management [1]
- ☐ HIV Case Management [1]
- ☐ Maternity Care Coordination (MCC)/Child Service Coordination (CSC) Services [1]
- ☐ Targeted Case Management for Developmental Disabilities[1]

Community Program – See Page 3 & 4

- ☐ Community Alternatives Program (CAP) [1]
- ☐ Community Intervention Services (CIS) [1]
- ☐ Critical Access Behavioral Health Agency (CABHA) [1]

Group Home – See Page 4

- ☐ Adult Care Home [1]
- ☐ ICF, MR – Privately Owned [1]
- ☐ ICF, MR – State Owned [1]
- ☐ Residential Treatment Facility
- ☐ Therapeutic Family Services[1]

HMO

- ☐ ACCESS II – Community Care [1]
- ☐ Mental Health HMO (Piedmont) [1]
- ☐ ACCESS II – Enhanced Care [1]
- ☐ PACE (Program of the All-Inclusive Care for the Elderly) [1]

Home Health Programs

- ☐ Home Health Agency [1]
- ☐ Home Infusion Therapy (HIT) [1]
- ☐ Hospice [1]
- ☐ Personal Care Service (PCS) [1]
- ☐ Private Duty Nurse [1]

Independent Practitioner (non-physicians)

- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Independent Practitioner
- ☐ Nurse Midwife
- ☐ Nurse Practitioner
- ☐ Outpatient Behavioral Health [1]

Inpatient Facilities – See Page 3 & 4

- ☐ Critical Access Hospital [1]
- ☐ Hospital
- ☐ Nursing Facility
- ☐ Psychiatric Hospital – Privately Owned [1]
- ☐ Psychiatric Hospital – State Owned [1]
- ☐ Psychiatric Residential Treatment Facility (PRTF) - Privately Owned
- ☐ Psychiatric Residential Treatment Facility (PRTF) - State Owned [1]

Lab, Radiology, Pharmacy, DME

- ☐ Cochlear Implant External Parts/Repairs
- ☐ Durable Medical Equipment (DME)
- ☐ Independent Diagnostic Testing Facility (IDTF) [1]
- ☐ Independent Laboratory
- ☐ Pharmacy
- ☐ Portable X-Ray and Ultrasound [1]

Outpatient Clinic/Facility

- ☐ Ambulatory Surgery Center
- ☐ Birthing Center
- ☐ Dialysis Center
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Planned Parenthood [1]
- ☐ Rural Health Clinic (RHC)

Doctor of Medicine or Dentistry

- ☐ Chiropractor
- ☐ Optometrist
- ☐ Dentist
- ☐ Orthodontist
- ☐ Oral Surgeon
- ☐ Physician Group
- ☐ Periodontist
- ☐ Pedodontist
- ☐ Podiatry

State Agencies

- ☐ Health Department [1]
- ☐ Local Education Agency (LEA) [1]
- ☐ Local Management Entity (LME) [1]

[1] Only in state providers can enroll.

CAP Service(s) (Choose all that apply)

CAP/DA (Disabled Adult) Services[1]

- ☐ Adult Day Health Care
- ☐ Case Management
- ☐ Home Delivered Meals
- ☐ Home Mobility Aids
- ☐ In-Home Aide Level II
- ☐ In-Home Aide Level III Personal Care
- ☐ Medical Supplies
- ☐ Personal Emergency Response System (PERS)
- ☐ Respite Care – In-Home
- ☐ Respite Care – Institutional
- ☐ Waiver Supplies

CAP/C (Disabled Children/Katie Beckett) Services[1]

- ☐ Attendant Care
- ☐ CAP/C Nursing
- ☐ Care Giver Training
- ☐ Case Management
- ☐ Community Transition Funding
- ☐ Home Mobility Aids
- ☐ Medical Supplies
- ☐ Palliative Care
- ☐ Pediatric Nurse Aide Services
- ☐ Personal Care
- ☐ Respite Care – In-Home (Aide)
- ☐ Respite Care – In-Home (Nursing)
- ☐ Respite Care – Institutional
- ☐ Vehicle Modification
- ☐ Waiver Supplies

CAP-MR/DD (Mentally Retarded/Developmentally Disabled) Services

- ☐ Adult Day Health Care [1]
- ☐ Augmentative Communication Devices
- ☐ Crisis Respite
- ☐ Crisis Services
- ☐ Day Supports
- ☐ Home and Community Supports
- ☐ Home Modifications
- ☐ Home Supports
- ☐ Individual/Caregiver Training & Education
- ☐ Long-term Vocational Supports
- ☐ Personal Care Services
- ☐ Residential Supports
- ☐ Respite Care- Facility Based with 24 hrs awake staff
- ☐ Specialized Consultative Services
- ☐ Respite Care – Non-institutional Community Based
- ☐ Respite Care – Non-institutional Nursing- Based
- ☐ Respite Care – Institutional
- ☐ Specialized Equipment and Supplies
- ☐ Supported Employment
- ☐ Transportation
- ☐ Vehicle Adaptations
- ☐ Personal Emergency Response System (PERS)[1]

CIS Services (Choose all that apply)

- ☐ Ambulatory Detoxification
- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Community Based Rehabilitative Service – Early Intervention[1]
- ☐ Community Support - Child
- ☐ Community Support - Team
- ☐ Diagnostic Assessment
- ☐ Intensive In Home
- ☐ Medically Supervised or ADATC Detoxification/Crisis Stabilization
- ☐ Mobile Crisis Management
- ☐ Multi-Systemic Therapy
- ☐ Non-Hospital Detoxification
- ☐ Opioid Treatment
- ☐ Partial Hospitalization
- ☐ Professional Treatment Services in Facility Based Crisis Programs - Child
- ☐ Professional Treatment Services in Facility Based Crisis Programs - Adult
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment

[1] Doesn't require endorsement

CABHA Services (Choose all that apply)

In order to become a CABHA provider, you must provide the following three services:

- ☐ Comprehensive Clinical Assessment
- ☐ Medication Management
- ☐ Outpatient Therapy

In addition to the three above, you must also select a minimum of two services below:

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Intensive In-Home
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Partial Hospitalization
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

In addition to the above, you may also provide the following two services below:

- ☐ Targeted Case Management for Mental Health and Substance Abuse NPI#_____
- ☐ Peer Support

(Please list NPI# for TCM/MH-SA if different than CABHA NPI#.)

Group Homes and Inpatient Facilities – CABHA Only

Bed Accommodations

Type of Bed Accommodations	# of beds
Residential Treatment Level II	
Residential Treatment Level III	
Residential Treatment Level IV	

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

(**ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)**

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

(**ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)**

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

(**ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)**

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

(**ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)**

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

(**ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)**

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Therapeutic Family Services

(**ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)**

Inpatient Facilities

Is this a Teaching Hospital? Yes No

Group Homes and Inpatient Facilities – Not for CABHA use

Bed Accommodations

Type of Bed Accommodations	# of beds	Type of Bed Accommodations	# of Beds
Acute		Adult Care Home	
Alzheimer's		Critical Care	
Geriatric		Group home	
Head Trauma		Intermediate Care Facility – MR	
Intermediate Care		Long Term Care	
Psychiatric		Rehabilitation	
Residential Treatment Level II		Residential Treatment Level III	
Residential treatment Level IV		Skilled Nursing Facility	
Specialty – Other		Sub Acute	
Substance Abuse		Swing	
Ventilator Dependent			

Certification, Licensure, Accreditation and Endorsement

Please complete required certification, licensure, accreditation, and endorsements as applicable

Medicare Number	CLIA Number	DEA Number

Certification

Certifying Entity 1

Current Effective date	Expiration Date	State	Certificate Number

Certifying Entity 2

Current Effective date	Expiration Date	State	Certificate Number

License

Licensing Entity 1

Current Effective Date	Expiration Date	State	License / Certificate Number

Licensing Entity 2

Current Effective Date	Expiration Date	State	License / Certificate Number

Accreditation

Accreditation Entity

Current Effective Date	Expiration Date	State	Accreditation Number

Local Management Entity (LME) Endorsement

Notification of Endorsement by the LME is required for all CIS Services except Early Intervention Service, all CABHA Services and all CAP/MR-DD Services except PERS and Adult Day Health.

List the Local Management Entity that conducted your business verification

Physical Address Information (Physical Site Location)

This is the physical location where service will be rendered, or in the case of mobile services, where management/supervision occurs. (No P.O. Boxes)

Address Line 1 *

Address Line 2

City *	State *	Zip Code+4 *

County *

Contact Person (Authorized Individual)

Individual authorized to receive information or make business decisions on behalf of the applying provider.

Full Name (Last, First, Middle) *		Business Relationship to Enrolling Provider (Title) *	
Office Phone Number * ( ) -	Ext	Other Phone Number ( ) -	Ext
Fax Number ( ) -		Email Address *	

Correspondence / Accounting Address Information

This is the address where all paper and accounting correspondence is to be mailed.

☐ Check if correspondence address is the same as the physical address listed on this application

Attention *

Address Line 1 *

Address Line 2

City *	State *	Zip Code *

Correspondence Contact Person

☐ Check if correspondence person is the same as the contact person (authorized individual)

Full Name (Last, First, Middle) *		Business Relationship to Enrolling Provider (Title) *	
Office Phone Number * ( ) -	Ext	Other Phone Number ( ) -	Ext
Fax Number ( ) -		Email Address	

Servicing Counties

List the North Carolina counties where the recipients you will see are located.

☐ Check if you serve all counties in North Carolina.

*			

Hours of Operation *

Indicate the hours the provider is available to see recipients at this location.

☐ Check if this location is open 24/7

	Open	Hours closed during the work day		Close
		Close	Open	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
Total hours available to see recipients				

After Hours Coverage or 24/7 Responder Coverage

Phone Number *

( ) -

Type of after hours or 24/7 responder coverage *

- ☐ Answering Service
- ☐ Answering machine that gives phone number of the provider
- ☐ Nurse Triage Service
- ☐ Physician on call
- ☐ Other:
- ☐ Hospital operator who pages on-call provider
- ☐ Call forward or stay-on-line transferring
- ☐ 24 hour Hospital Switchboard
- ☐ ER Triage

Interpretation Services *

Are Oral Interpretation Services available?	☐ Yes	☐ No
Is Braille supported?	☐ Yes	☐ No
Is Sign Language Supported?	☐ Yes	☐ No

Ages and Gender Served *

Please provide gender and ages served at the location.

☐ Male	Ages Served:
☐ Female	Ages Served:

Languages Supported *

Select all languages that are spoken or supported at your physical location.

☐ Arabic	☐ French	☐ Japanese	☐ Spanish
☐ Armenian	☐ German	☐ Korean	☐ Tagalog
☐ Chinese	☐ Greek	☐ Persian	☐ Thai
☐ English	☐ Hindi	☐ Polish	☐ Vietnamese
☐ French Creole	☐ Italian	☐ Portuguese	☐ Yiddish
☐ Other:			

Special Needs

Check all special needs services your physical location is equipped to serve. *

☐ Blind / Visually Impaired	☐ Sexually Aggressive
☐ Deaf / Hearing Impaired	☐ Behaviorally Disruptive
☐ Physical Handicapped	

TDD/TTY Phone Number

( ) -

Patients Accepted *

Are you accepting new patients?	Yes	No
If no, do you accept siblings of established patients?	Yes	No
Do you accept Medicaid for Pregnant Women (MPW) patients?	Yes	No
If yes, do you serve patients other than MPW?	Yes	No
Do you accept Chronic Infectious Disease patients?	Yes	No

Taxonomy Codes

Please enter all the taxonomy codes that are registered with your NPI.

*			

Hospital Admitting

Does a clinician in this group or practice have hospital admitting privileges? * ☐ Yes ☐ No

Please list all Hospitals that you have admitting privileges

	Hospital Name	County
1)		
2)		
3)		
4)		

Managing Relationships

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator), and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

Relationship 1

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 2

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 3

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 4

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 5

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 6

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Managing Relationships Continued . . .

Relationship 7

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 8

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 9

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 10

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 11

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 12

Full Name (Last, First, Middle) *	
Social Security Number* - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership Information

How would you describe the ownership? *

☐ Single-Owner LLC ☐ Sole Proprietor

☐ Federal ☐ State ☐ City/Municipality ☐ Indian Health Services

☐ Corporation ☐ Partnership ☐ Non-Profit

Corporation, Partnership, or Non-Profit:
Does anyone have direct or indirect ownership or control interest of 5% or more in the organization/entity? * ☐ Yes ☐ No

If you answered yes to the above question you must list ownership information for each owner who owns 5% or more.

Ownership 1

Full Name (Last, First, Middle) / Business Name*

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 2

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 3

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 4

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 5

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership Information Continued . . .

Ownership 6

Full Name (Last, First, Middle) / Business Name*

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 7

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 8

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 9

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 10

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Ownership 11

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*	

Physician Extender Information

Are there physician extenders practicing at this location? * ☐ Yes ☐ No

If yes, please provide the following information for each physician extender practicing at this location.

Physician Extender 1

Full Name (Last, First, Middle)

☐ Nurse Practitioner ☐ Physician Assistant

☐ Nurse Midwife ☐ Certified Advanced Practice Nurse Specialist

Physician Extender 2

Full Name (Last, First, Middle)

☐ Nurse Practitioner ☐ Physician Assistant

☐ Nurse Midwife ☐ Certified Advanced Practice Nurse Specialist

Affiliated Provider Information

Provide the individual NC DHHS Number, NPI, and the name information for each provider that you wish to link or affiliate with this organization. Physician, CRNA, Multiple Independent Practitioner, and Nurse Practitioner groups must have at least one individual provider who is actively enrolled as a NC Medicaid Provider. Entries must match those on your ECS Agreement.

NC DHHS Number *	NPI *	Provider Name *

Border Providers Only - Home State Medicaid Program Information

Please provide identifying information regarding you home state's Medicaid program.

NPI Number * | Provider Number

State Medicaid Program Address 1 *

State Medicaid Program Address 2

City * | State * | Zip * | State's Medicaid Phone Number * ( ) -

Exclusion Sanction Information *

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

* An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
* A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
* An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

For each question answered yes, the applicant must attach or submit a complete copy of the applicable criminal complaint, Consent Order, documentation, licensure action, suspension, penalty or recoupment notice, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

A.	Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, pled no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense?	Yes	No
B.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had disciplinary action taken against any business or professional license held in this or any other state, including licenses issued by the North Carolina Division of Health Service Regulation (NC DHSR) and endorsements issued by any Local Management Entity as that term is defined in N.C.G.S. 122C-115.4?	Yes	No
C.	Has your license to practice ever been restricted, reduced or revoked in this or any other state or been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying or professional standards board or agency?	Yes	No
D.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?	Yes	No
E.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had payments suspended by Medicare or Medicaid in any state?	Yes	No
F.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including NC DHSR, even if the fine(s) have been paid in full?	Yes	No
G.	Have Medicare or Medicaid in any state ever taken recoupment actions against you or any entity you are or were either an agent, owner, or managing employee of?	Yes	No
H.	Do you or any entity you are or were either an agent, owner, or managing employee of, owe money to Medicare or Medicaid that has not been paid in full?	Yes	No
I.	Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?	Yes	No
J.	Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	Yes	No
K.	Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct?	Yes	No
L.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?	Yes	No

Consent to Release Information

I understand that the North Carolina Division of Medical Assistance (DMA) and its representatives is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA and its representatives to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program's credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

Signature of Authorization Required

Information Must Be Entered For The Agreement To Be Processed
I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

Signature of Authorized Individual *	Date *

Print Name *	Title *

North Carolina Department of Health and Human Services

PROVIDER ADMINISTRATIVE PARTICIPATION AGREEMENT

1. Parties to the Agreement

This Medicaid Provider Administrative Participation Agreement ("Agreement") is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the "Department", and the below identified provider, hereinafter referred to as the "Provider."

STATE/FISCAL AGENT USE ONLY

- ☐ **Initial Enrollment**
- ☐ **Re-Enrollment**
- ☐ **CHOW**
- ☐ **Other Change**

2. Agreement Document

The Agreement Documents shall consist of this Agreement, any addendum, and the Provider's application, incorporated herein by reference. Except for changes to DHHS medical coverage policies, or other guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent as referenced in Section 3, below, no alterations or modifications shall be made to the terms of the Agreement unless through a written amendment executed by both parties.

3. Governing Law and Venue

This Agreement is required by 42 CFR §431.107 and shall be governed by the following (hereinafter referred to as the "Controlling Authority"):

(a) Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, and any Title XIX waivers authorized by the Centers for Medicare and Medicaid Services (CMS); and
(b) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, including but not limited to the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards; and
(c) The Family Educational Rights and Privacy Act (FERPA); and
(d) N.C.G.S §108A-80; and
(e) The following that are consistent with and expressly or implicitly authorized by the authority in subdivision (a) herein: state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered.

By execution of this Agreement, the Provider does not release, waive or modify in any way any procedural or substantive rights it may have pursuant to Controlling Authority related to its participation in the Medicaid program. In case of conflict between any provision of this Agreement and any current or future provision of Controlling Authority, the Controlling Authority shall govern and the terms of this Agreement shall be deemed to be modified so as to comply with Controlling Authority. In the event of a

lawsuit or administrative petition involving this Agreement, venue is proper in Wake County, North Carolina.

The Provider agrees to operate and provide services in accordance with the Controlling Authority. Unless otherwise required by this Agreement or Controlling Authority, the Department may publish notice of changes in policies, guidelines, or other procedures on its website within 30 days advance notice to provide for implementation thereof.

Nothing in this Agreement creates in the provider a property right or liberty right in continued participation in the North Carolina Medicaid program.

4. License

The Provider agrees to:

a. Be licensed, certified, registered, accredited and/or endorsed as required by Controlling Authority or Department policy, as appropriate for the service provided by the Provider, at all times those services are provided.
b. Notify the Department within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.

5. Billing and Payment

The Provider agrees:

a. To submit claims for services rendered to eligible North Carolina Medicaid recipients (hereinafter "recipients") in accordance with rules and billing instructions in effect at the time the service is rendered. Provider agrees to be responsible for research and correction of all billing discrepancies in claims submitted by the Provider or its authorized agent.
b. To accept as sole and complete remuneration the amount paid in accordance with the finally determined reimbursement rate for services covered by the Department, except for payments from legally liable third parties, and authorized co-payments, coinsurance and/or deductibles authorized by the Controlling Authority or the Department. A Provider may bill for goods, services, or supplies provided to a recipient if such are not covered under Medicaid and the recipient has been notified in advance that such services are not covered and that the recipient is financially responsible. By agreeing to this provision, the Provider does not waive any potential rights to challenge or appeal its reimbursement rate or payment calculation in accordance with Controlling Authority.
c. That in no event shall the Department be liable or responsible, either directly or indirectly, to any subcontractor of the Provider or any other party that may provide services.
d. To be held to all the terms of this Agreement even though a third party agent may be involved in billing claims to the Department. It is a breach of the Agreement to assign the right to payment under this Agreement to a third party in violation of 42 CFR §447.10.
e. To inquire about other coverage and bill other insurers and third parties, including the Medicare program, if applicable, before billing the Department, when the recipient is eligible for payment for health care or related services from another insurer or person.
f. To not bill the recipient or any other person for items and services covered by Medicaid and to refund payments made by the recipient or by a third party on behalf of the recipient for Medicaid covered services for any claims for which the recipient has been approved for payment by the Department, including retroactive authorization for payment. No refund is due by the Provider to the recipient or any

other person until payment to the Provider is final and has been made in full by Medicaid to the Provider.

g. To accept assignment of Medicare payment in order to receive payment from the Department for amounts not covered by Medicare for dually eligible recipients.
h. To refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the Provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the Provider or the Department and/or its agents.
i. That payment for covered services by the Department is limited to those services that are medically necessary. Medical necessity and appeals of medical necessity determinations will be determined in accordance with the Controlling Authority.
j. That items or services provided under arrangements or contracts between the Provider and outside entities and professionals shall meet the same professional standards and principles as herein agreed to by the Provider.
k. That payment and satisfaction of claims will be from federal and state funds.
l. That claims are subject to the Medical Assistance Provider False Claims Act (Part 7, Article 2, Chapter 108A of the General Statutes), the North Carolina False Claims Act, Chapter 1, Article 51 of the North Carolina General Statutes (N.C.G.S §§1-605 through 617), and the federal False Claims Act.
m. That the Department may withhold payments because of irregularity without regard to cause until such irregularity is resolved, or may recoup or recover overpayments, penalties or invalid payments due to error of the Provider and/or the Department and their agents. The Department shall provide timely notice to the Provider that states the Department's reasons for withholding payments, the conditions that must be met to resolve the irregularity and the Provider's right to appeal. This withhold shall be subject to adjustment in accordance with Controlling Authority as a result of any contrary final determination in any challenge or appeal brought by the Provider. The Department may also withhold or suspend payments to a Provider as authorized by Controlling Authority. A Provider that is subject to a withhold recoupment, recovery, suspension, or penalty initiated by the Department shall not directly or indirectly bill through a different provider number for the purpose of evading the action.
n. Any Providers that share the same IRS Employee Identification Number are equally subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until any overpayment, penalty, or invalid payment incurred by such Provider(s) is resolved, either by payment in full or final agency decision. Any Provider that does not share the same Employee Identification Number but that is more than fifty percent (50%) owned, in whole or in part, by an individual or entity that has more than fifty percent (50%) ownership interest in a separate provider entity that owes an outstanding overpayment, penalty, or invalid payment to the Department shall also be subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until such overpayment, penalty, or invalid payment is resolved, either by payment in full or final agency decision.
o. That billings and reports related to services rendered shall be submitted in the format and frequency specified by the Department, any of its divisions and/or its fiscal agent. Failure to file mandatory reports or required disclosures within the time frames established by Department rule or policy may result in suspension of payments and/or other enforcement actions.
p. That claims shall be received by the Department within 365 calendar days of the date of service except as otherwise provided by Controlling Authority.
q. That electronic and non-electronic Medicaid claims may be submitted without signature and same is binding upon Provider, its employees, or its agents who provide services to recipients or who file claims under the Provider name and identification number.
r. That all claims shall be true, accurate, and complete and that services billed shall be personally furnished by Provider, its employees, or persons with whom the Provider has contracted to render services, under its direction.
s. That, except for hospital services as set forth in 42 CFR §413.65 the assigned Medicaid Provider Number

is specific to the Provider name and site location identified on the signature page of this Agreement, and that Provider shall not bill for services provided at or from other site locations using Medicaid Provider Number assigned to the site location identified on the signature page of this Agreement.

t. That any change of ownership of Provider shall not be approved unless and until the new owner/entity agrees in writing to assume all liability, including but not limited to cost report settlements, health care assessment settlements, or recoupment actions, that have arisen or that may arise in connection with claims billed by Provider.

u. To not bill the Department for services that were rendered during any period in which the institutional or professional license, certification, registration, accreditation and/or endorsement required of the individual or entity providing the service has become invalid due to suspension or termination by the issuing agency.

6. Disclosure

a. At any time during the course of this Agreement, the Provider agrees to notify the Department at the North Carolina Department of Health and Human Services, Division of Medical Assistance, Provider Services Section, of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in:
   i. ownership;
   ii. licensure;
   iii. federal tax identification number;
   iv. bankruptcy;
   v. additions, deletions, or replacements in group membership; and
   vi. any change in address or telephone number.

b. The Provider agrees to submit to the Department upon request professional, business, and personal information concerning the Provider, any person with an ownership interest in the Provider, and any authorized agent of the Provider in accordance with the disclosure requirements set forth in 42 CFR Chapter IV, part 455, Subpart B. Such submittal shall include:
   i. Proof of a valid license, operating certificate, and/or certification if required by Controlling Authority or policy, or rule of a local jurisdiction in which the Provider is located and that is consistent with Controlling Authority.
   ii. Any prior or current violation, recoupment, fine, suspension, termination, or other administrative action taken relative to medical or behavioral health care benefit programs under (a) federal or State law, policy, or rule; or (b) Department policy(ies) or (c) the laws or rules of any other state, Medicare, or any regulatory body.
   iii. Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other medical or behavioral health care provider or medical or behavioral health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide medical or behavioral health care services.

c. The Provider agrees to furnish on request, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

d. The Provider agrees to submit to a criminal background check before or anytime after approval of this agreement.

e. The Provider agrees to screen all its employees and contractors regularly using the List of Excluded Individuals/Entities (LEIE) database to determine whether any of its employees or contractors is excluded from participation in Medicare, Medicaid, or other federal health care programs. The LEIE database is maintained by the United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG) and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The Provider shall promptly notify the Department upon discovery that any employee or contractor is on the LEIE. Provider understands and acknowledges that employment of or contractual arrangements with persons listed in the LEIE will subject the Provider, in accordance with Controlling Authority, to recoupment of funds paid to the Provider during the period in which the employment or contract was in effect.
f. The Provider agrees to comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR Chapter IV, part 489, subpart I and 42 CFR §417.436(d).

7. Inspection; Maintenance of Records; Filing Reports

a. For a minimum of six years from the date of services, or longer if required specifically by Controlling Authority, the Provider shall:
    i. Promptly furnish upon request copies of any and all documentation set forth below in subpart ii of this paragraph, whether in the possession of contractors, agents, or subcontractors, for review by the Department, its agents and/or assigns. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for medical or behavioral health care services not adequately documented, and may result in the termination or suspension of the Provider from participation in the Medicaid program. The Provider further understands that it is the Department's position that failure to promptly furnish records upon request creates a presumption that the records do not exist.
    ii. Keep, maintain and make available complete and accurate medical and fiscal records in accordance with Department record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Department. For providers who are required to submit annual cost reports, fiscal records shall include invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, and such other records as may be required by Controlling Authority or Department policy.
b. Post payment audits or investigation may be conducted to determine compliance with the rules and regulations of the Department. If the Provider is notified that an audit or investigation has been initiated, the Provider shall retain all original records and supportive materials until the audit or investigation is completed and all issues are resolved if the period of retention extends beyond the minimum required 6-year period.
c. Federal and State officials, employees and their agents may visit Provider facilities to make certification and compliance surveys, inspections, medical and professional reviews, and audits of costs and data relating to services to recipients. Such visits including unannounced visits must be allowed at any time during normal hours of operation. Failure to grant immediate access upon reasonable request may result in suspension of the Provider and/or of reimbursements.

8. Termination

Subject to applicable provisions of Controlling Authority:
a. Either the Department or the Provider may terminate this Agreement with or without cause at any time upon 30 days written notification to the other;

b. The Department may summarily terminate without giving 30 days written notice under the following circumstances:
   i. The Provider does not meet conditions for participation, including necessary licensure, certification, or endorsement requirements or other terms and conditions stated in this Agreement; or
   ii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense set forth in 42 CFR §1001.101 or 42 CFR §1001.201; or
   iii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct, or crime of moral turpitude; or
   iv. The Provider fails to disclose information required under 42 CFR §1002.3; or
   v. Any person with ownership or controlling interest in the Provider, or an agent as that term is defined in accordance with 42 CFR §1001.1001 or managing employee of the Provider, has been excluded by the United States Department of Health and Human Services from participation in the Medicare or Medicaid programs; or
   vi. The Provider poses an imminent health or safety risk to a patient; or
   vii. The Provider has been found by the Department to be in breach or violation of any law, rule, or policy for which summary termination is authorized by Controlling Authority or by a rule authorized by and consistent with the Controlling Authority and adopted pursuant to Chapter 150B of the General Statutes; or

The Provider's right to appeal or otherwise contest any termination shall be determined in accordance with Controlling Authority.

9. Assignment

The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement to a third party except as allowed by federal law.

10. Release of Liability

The Provider agrees to fully release and discharge the State of North Carolina, the Department and any of their officers, agents and employees, from any and all liability, claims and causes of action that may be brought by third parties against the Provider arising out of this Agreement. This is a complete and irrevocable release and waiver of liability. The State of North Carolina, the Department, and any of their officers, agents and employees are not liable for claims and causes of action that may be brought by third parties arising out of any act or omission of the Provider or any subcontractor.

11. Severability

The provisions of this Agreement are severable. If any provision of the Agreement is held invalid by any court that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be modified to conform to existing law.

12. Independent Contractor

The Provider or its directors, officers, partners, employees and agents are not employees or agents of the Department.

13. Discrimination

The Provider agrees that the Department may make payments for medical or behavioral health care services rendered to Department recipients only to a person or entity who has a provider agreement in effect with the Department; who is performing services or supplying goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964; Section 504 of the 1973 Rehabilitation Act; the 1975 Age Discrimination Act; the 1990 Americans With Disabilities Act; and all applicable federal and state statutes and regulations relating to the protection of human subjects of research. The authority of the Department and its Division of Medical Assistance to limit payment to the Provider under this Section or otherwise shall be restricted exclusively to payments for services rendered on specific dates as to which the above-referenced requirements were not met.

14. Waiver

No waiver of any term, right or condition of this Agreement shall be valid unless it is set forth in a writing duly executed by both parties. No delay or failure by either party to exercise or enforce at any time any right or provision of this Agreement will be considered a waiver thereof or of such party's right thereafter to exercise or enforce each and every right and provision of the Agreement. No single waiver will constitute a continuing or subsequent waiver.

15. Survival

All provisions of this Agreement which by their nature give rise to continuing obligations of the parties shall survive the expiration or termination of this Agreement, including without limitation the terms of paragraphs 3, 5, 7, 9, and 10.

16. Effective Date

This Agreement is effective on the date the Provider meets all requirements of participation as set forth in 42 CFR §431.108.

Required Fields are marked with an asterisk (*).

*Medicaid Provider Name (Last, First, Middle or Organization Name)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

*Street Address Line 2 *Phone Number

*City *State *Zip Code + Four (Last 4 digits required)

*Correspondence Address Line 1 (Accounting)

*Correspondence Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

* Medicaid Provider Number (if applicable)

I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

*Signature of Applicant or Authorized Agent *Date

*Printed Name and Title

DHHS/DMA/FISCAL AGENT APPROVAL

*Signature *Date

North Carolina Department of Health and Human Services

MEDICAID LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall –

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner/ operator/ manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least $5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 *et seq.,* administrative remedies for false claims and statements established under 31 USCS §. 3801 *et seq.,* and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Signature of Applicant or Authorized Individual *Date

*Printed Name and Title

Required Fields are marked with an asterisk (*).

North Carolina Department of Health and Human Services
Division of Medical Assistance
PROVIDER CERTIFICATION FOR SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

A separate certification is required for each individual in the group in addition to the group certification.

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

_____

*Signature of Applicant or Authorized Individual *Date

_____

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date: _____ by _____

North Carolina Department of Health and Human Services

Division of Medical Assistance

Instructions for Completing the Electronic Claims Submission (ECS) Agreement

Providers who plan to submit claims electronically must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims.

The ECS Agreement is not transferable from one group practice to another, from one owner of a group practice to another or for individual providers affiliated with a group practice moving to another group practice or a solo practice.

Who Needs to Submit an ECS Agreement?

1. Currently enrolled organizations (group practices or agencies/facilities) who did not elect to submit claims electronically at the time of their initial enrollment must complete and submit an ECS Agreement prior to beginning electronic claims submission. The ECS Agreement must include the original signature of each individual provider affiliated with your group.
2. Currently enrolled organizations (group practices) who completed and submitted an ECS Agreement and who have subsequently added new individual providers to their group practice must complete and submit an additional ECS Agreement with the original signature of the new individual providers.
3. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

How to Complete the Form:

1. Type or print in black ink.
2. The ECS Agreement cannot be altered; text cannot be highlighted, struck through, or obstructed through the use of correction fluids.
3. The ECS Agreement must be submitted to CSC by mail; ECS Agreements sent by fax are not acceptable.
4. Provider Name
   a. Enter the name of your group practice or agency/facility.
   b. The provider name entered on the ECS Agreement must match the name on file with the N.C. Medicaid Program (as indicated on your Remittance and Status Report).
   c. If the name of your group practice or agency/facility has changed, you must submit a correction according to the process outlined on CSC's website at http://www.nctracks.nc.gov/provider/cis.html.
   d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.
5. Provider Number

   Enter the Medicaid Provider Number for the group practice or agency/facility. Payments will be made to this Medicaid Provider Number.

6. Business Site/Physical Address
   a. Enter the physical address for the group practice or agency/facility. (The physical address is the street address for the location where services will be rendered.)
   b. The physical address entered on the ECS Agreement must match the address on file with the N.C. Medicaid Program.
   c. If the physical address for your group practice has changed, you must submit a correction according to the process outlined on CSC's website at http://www.nctracks.nc.gov/provider/cis.jsp.
   d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.
7. Group Practice Member Information
   a. This portion of the ECS Agreement must be completed by an enrolled group practice when they elect to submit claims electronically. Enter the name and Medicaid Provider Number for each individual provider affiliated with your group for whom you will be submitting claims using your group provider number. This is required even if there is only one provider in the group.
   b. This portion of the ECS Agreement must be completed by an enrolled group practice when a new individual is added to the group practice. Enter the name and Medicaid Provider Number for only the new individual provider for whom you will be submitting claims using your group provider number.
   c. The individual provider(s) must sign where indicated. All signatures must be original; signature stamps and copies are not acceptable.
   d. This portion of the ECS Agreement is not applicable to agency/facility providers.
8. Signature Authorization and Related Information

   An authorized agent such as the medical director, owner, vice president, business officer, etc., who has the authority to enter into contracts on behalf of the group must sign group ECS Agreement.
   a. All signatures must be original.
   b. Signature stamps are not acceptable.
   c. Photocopies are not acceptable.
9. Claims should not be submitted electronically until notification of approval of the ECS Agreement is received from CSC. You must contact the ECS unit at EDS by calling 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) to obtain an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to CSC:

USPS Mail:
CSC EVC Center
P. O. Box 300020
Raleigh, NC 27622-8020

For certified /overnight mail only:
CSC EVC Center
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073

North Carolina Department of Health and Human Services
Division of Medical Assistance
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

1. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents.

Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.
8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.
9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.
10. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.
11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.
12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.
13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.
14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name: _____

(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

***Provider Name**	***Provider Individual Number**	***Signature of Provider**

*Provider Name	*Provider Individual Number	*Signature of Provider

(Attach additional sheets if necessary)

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Signature of Authorized Agent *Date

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date by

Substitute W-9

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership

☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* in the instructions.

Note. If the account is in more than one name, see the Instructions for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notifiedby the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions.

Sign Here **Signature of U.S. person** ▶ **Date** ▶